The Enemy Uncovered

Carvalho Filho, Marco Antonio

Published in:
Professional Formation - The Newsletter of the Academy for Professionalism in Healthcare

July 2018

Professional FormationPFO

Update on Healthcare Professionalism Education, Assessment, Remediation & Research

A newsletter produced jointly for the Academy for Professionalism in Health Care and ProfessionalFormation.org

---

From the Editor - Janet de Groot

Dear Readers,
Along with our managing editor, Barbara Lewis, I am very pleased to forward our July 2018 newsletter. This month, our authors' series of articles draw our attention to health professions student experience in the process of developing professional identities and challenges in that regard.

Defining Civility
Building on a Code of Conduct to educate for professionalism, Stephen Gambescia and Katherine Anselmi define what civility is and what it is not. They do so to support nursing and health professions students to enact their professional role, which has higher expectations for civility than those not in the health professions. In particular, they highlight the need to be aware of and clearly recognize *the oth*er in all interactions, in the public. This is consistent with *relational ethics*, wherein the relationship between the patient or client and practitioner is seen to be where all ethical interactions occur (1). In this regard, it is thought that an empathic connection with patients or clients, not just the provision of a service, that supports practitioners to be professional and trustworthy (2). Nevertheless, the capacity to remain in connection may be challenging at times.

The Enemy Uncovered: Hidden Curriculum and Professional Identity
Marco Antonio de Carvalho-Filho vividly describes the value of awareness of the hidden curriculum as a force, nourished by hierarchy that may adversely affect whether medical students can retain their moral values. He notes that the hidden curriculum is both universal and particular, the latter influenced by organization structure. Clearly, he is a trusted educator whom students spoke to about their challenges in retaining moral values. Within student-preceptor relationships, he and his colleagues are addressing the need to retain moral values through reflective spaces, some of which are highly effective and unique, such as the Theatre of the Oppressed. One could speculate that the challenges his and many medical students are confronting, is clinicians who are having difficulty living up to the high expectations for civility, challenged in maintaining connection with those they care for, due to time demands and other systemic issues (3).

Humor, Students and Professionalism
John Minser further provokes our reflection on the intersubjective and organizational *spaces* within medical students encounter gallows and derogatory humour by health professionals during clinical rotations. The hidden curriculum is again in evidence, wherein health professionals find mechanisms to address challenges in the workplace. John Minser's article prompted me to think further about organizational ethics, the need for institutions to provide mechanisms to support not only trainees, but also health providers who confront so much more pain, suffering and death than those not in the health professions.

How We Do Harm: A Doctor Breaks Rank About Being Sick in America
This month's book review, by our regular contributor, Leann Poston informs us how the author, Dr. Otis Webb Brawley in Atlanta Georgia, provides patient narratives to educate us about big picture conflicts between humanistic care and financial interests. The patient stories vary by socio-economic status, being of color or not, and by opportunities to seek second and even third opinions and convey how these social determinants influence outcomes. This book may be valuable to health providers and for consumers to inform them about the conflicts.

Each of these articles encourage us to think more deeply about role modelling and communities of practice. How do we remain resilient and retain our capacity to convey compassion, be empathic and ensure excellent healthcare?

Best regards,
Janet

References

1. Austin, W., Brintnell, S., Goble, E., Kagan, L., Kreitzer, L., Larsen, D., & Leier, B. (2013). Differing Understandings of Compassion Fatigue. Chapter in *Lying Down in the Ever-Falling Snow: Canadian healthcare professionals' experience of compassion fatigue.* Waterloo, ON: Wilfrid Laurier University Press.
2. Gadow, S. "Narrative and Exploration: Toward a Poetics of Knowledge in Nursing," *Nursing Inquiry* 2 (1995): 211–14.
3. de Groot, J., Topps, M., Kassam, A. (2018) Contexts and experiences of postgraduate medical residents in successfully addressing professionalism challenges. (published abstract). *Medical Education; 52(suppl. 1): 51.*

Janet de Groot, MD, FRCPC, M.Med.Sc.- Founding Editor, APHC-PFO Newsletter

---

Defining Civility

by Stephen Gambescia and Katherine Anselmi

The nursing faculty in the College of Nursing and Health Professions took a keen interest in improving how to assist students in understanding expectations of good conduct and professionalism. In 2007, a task force convened to develop a Code of Conduct, among other objectives. The purpose of the student conduct code document was to provide guidelines for nursing students concerning their professional conduct and character in the classroom, clinical settings and online classes and in communications. The document explicated the civil, ethical and respectful behavior expected of all nursing professionals. This code gave more specificity to a nursing student's professional conduct, compared to the general university's student code of conduct, since licensed health professionals in general and nursing students in particular, are held to a higher standard of conduct.

The eventual Code was organized around eight sections: 1. Purpose, 2. Rationale, 3. Student Civility, 4. Classroom Conduct, 5. Clinical Conduct, 6. Academic Integrity, 7. Communication and 8. Appendices. The document became an appendix in each nursing program's student handbook. It influenced other non-nursing program leaders to devise ways of communicating "good conduct" and professionalism. One area germane to the work we are doing in *education for professionalism* is defining more specifically for students what we mean be "**being civil."**

Civility and Uncivility Defined

Civility has to do with courtesy, politeness and good manners. Civility is the awareness and recognition of *others* in all interactions and demonstration of a high level of respect and consideration. In civility we recognize that no action of ours is without consequence to others or ourselves. We need to anticipate what these consequences will be and choose to act in a responsible and caring way. Some may also call this "The Social Compact or Contract," derived from the philosophies of Locke, Hobbes, Rousseau, among others. The Social Compact is a tacit agreement among individuals when they enter society that the latter is a space that is organized in consideration of order and mutual protection and welfare – it also implies respect for one another at its core.

Uncivil behaviors are acts of rudeness, disrespect and other breeches of common rules of courtesy. These acts of incivility range from disrespectful verbal and non-verbal behaviors to physical threats to another's well-being. Uncivility is a lack of awareness and recognition (intended or unintended) of *others* in our interactions when we fail to give them a high level of respect and consideration. Uncivility usually results when one does not anticipate how actions will affect others.

Core Concepts of Being Civil

- Shows common courtesy and respect
- Aware of others (corporeal, emotions and intellect)
- Actions have consequences (intended or unintended)
- Shows self-control
- Responsible for your personal actions
- Emotional intelligence

How Do You Know When You're Being Uncivil?

- Being rude, disrespect or lacking common courtesy
- Being insensitive to others' feelings
- Fail to see any consequences to one's actions
- Self-centered; lack of self-control
- Dismissive of personal responsibility in the school and work environment

Shift from Private to Public Sphere

One's behavior needs to change when moving from the private sphere to the public sphere. Sitting with feet tucked under you on your couch at home while watching TV is not uncivil. However, when sitting in the public sphere (classroom, dining hall, shuttle, public transportation, etc.) the context changes; therefore, behavior expectations change. Sitting this way in the public sphere can be considered uncivil, if not bad form. One needs to shift from his/her self-awareness used in the private sphere to awareness of others in the public sphere.

Anticipating Consequences of Actions

In the public sphere, you need to anticipate how others are affected by your actions (words and deeds) regardless of how insignificant they may seem. A routine, functional act in the private sphere may not be appropriate in the public sphere. One needs to be disciplined to shift from private to public sphere awareness and anticipate actions on others. This can also be interpreted as emotional intelligence, appreciation of the impact our words and actions have on others.

What you "Mean to (or not to) Do"

We stressed with students that being civil is part and parcel to professionalism for a student in the College of Nursing and Health Professions at Drexel. We explained that students are held to a higher standard of behavior. Their actions will be judged not only on what they know to do and not do but *what they should have known to do.* An example of this is explicated by several of the American Nurses' Association publications (see below) as well as the various jurisdictional Boards of nursing, medicine, law and other professions where licensure is required that regulate the licensee's professional conduct. Students are taught that what the licensee should have known to do is the standard that all licensed health professionals are held to and the individual is held accountable for conduct being one of the standards.

Contemporary Examples of Uncivil Behavior

Unfortunately, we are not at a loss of examples of uncivil behavior by high-profile people to show our students. Politicians, entertainers, sports stars, public servants, corporate leaders are all too frequently reported in the news for uncivil behavior and often with impunity. Almost daily we can read about an individual announcing their resignation from a prominent position for violating the social compact, rules of professional conduct and/or other torts that are legally actionable. The action could be an ethnic slur, poor choice of words, joke or comment about another, including language and conduct that reaches sexual harassment and/or assault. Think about how the person makes amends. The person usually apologizes by saying "I did not mean to…." or "I did not know it would have that effect on…." In most cases the jury of public opinion, aside from the petty politics, says that he or she "should have known better." In other words, the person is not excused for being less mindful of the act because he or she is held to a higher standard. This is the standard students in the College of Nursing and Health Professions – future health professionals – are held to and this Code of Conduct goes a long way to explicate these high bar expectations.

Stephen F. Gambescia, PhD is professor of health services administration and Katherine Anselmi is associate professor of nursing in the College of Nursing and Health Professions at Drexel University in Philadelphia.

The Enemy Uncovered: Hidden Curriculum and Professional Identity

by Marco Antonio de Carvalho-Filho

In a recent article published in Academic Medicine, Lawrence et al. challenged the validity of “Hidden Curriculum” as a concept (1). Their main argument refers to a possible lack of precision in the term accompanied by a lack of practical implications. Hafferty and Matiamakis rebutted: the plurality of definitions and nuances related to the term have opened the eyes of the medical education community to the complexity of the socialization process of medical students by revealing the unplanned forces that push medical students towards unprofessional behaviors (2). This essay aims to contribute to the debate sharing a story and two ideas.

The story: My first contact with the term “Hidden Curriculum” was six years ago when I was organizing the emergency medicine rotation at the University of Campinas in Brazil. At that time, we realized that last year medical students were fighting to keep their moral values against an undefined force nourished by the hierarchical environment of medical schools and hospitals. To my surprise, other schools were also facing the same problem. The hope arrived when in an insightful movement, social scientists named that force and gave birth to the concept of the Hidden Curriculum. Finally, our enemy was uncovered. When you name something, you get a sense of control that is vital to fighting back.

The resultant awareness guided the clinical teachers involved in the emergency training through the process of understanding the local nuances of the hidden curriculum. We got closer to students, listened to their demands, opened spaces for guided reflection, developed simulations and debriefing sessions to foster empathy and to discuss their professional identities (3-6). Clinical teachers often forget that medical students are critical human beings, even when they opt for silencing. They see, desire, think of, criticize, approve, disapprove, and incorporate or not, the behaviors they testify during the clinical activities; and, eventually, they suffer when the medicine they voted for and idealized succumbs to the constraints imposed by the health system or unprofessional doctors. Suffering in silence opens the door for emotional dissonance (7). Students feel powerless and abandoned.

As a counteroffensive, to give voice to medical students, we bridged the clinical training with the humanities developing a curricular course to address professional identity formation based on the “Theater of the Oppressed” by Augusto Boal (8). During his professional life, Boal developed a methodology to empower oppressed populations through theater. We called our initiative MEET: Medical Education Empowered by Theater. The consequence was the consolidation of a real community of practice shared by undergraduate students, residents, and teachers. The students are feeling safer and respected. We are proud. The change has begun.

The ideas: first, we believe that the hidden curriculum has two dimensions: one, universal and another, particular. The hidden curriculum is universal because all medical schools have to deal with unplanned elements of the socialization process of medical students. We have plenty of evidence showing that these unintended experiences can be extremely harmful. The hidden curriculum is also particular because different medical schools have different organizational cultures, with local nuances and singular rituals and norms. Why is it important to acknowledge both dimensions of the hidden curriculum? When we recognize its universality, we understand that we, clinical teachers, should question why the medical culture is nesting unprofessional silos strong enough to poison the moral commitment of idealistic medical students. The answer to this question can help us to figure out an organizational strategy to change this reality.

On the other hand, mapping the particularities within one medical school allows curriculum designers and course coordinators to target specific issues, such as identifying negative role models, problematic rotations, covert prejudice, practices of moral and sexual harassment, etc.

Second, the hidden curriculum represents a real source of emotional distress that contributes to burnout and cynicism, hampering the professional development of medical students. Moreover, cynicism is

eroding the social contract of the medical profession. The ultimate consequence is that young doctors do not feel empowered enough to become the agents of change we require, which is terrible for a health system that needs to adapt to an ever-evolving complex society. In a less hierarchical environment, each new group of young physicians could bring us, senior physicians, a singular opportunity to reflect on old professional habits; habits that we are not proud of perpetuating. In the actual context, however, medical students are faded to reproduce our mistakes in a vicious cycle.

To foster a professional identity committed with the moral values of the good medical practice, we need to dissect the hidden curriculum exposing and analyzing all its components. The hidden curriculum is more than a concept; it is a reality that we urge to change. A change that may rescue our social contract. Highlight: Medical students are newcomers, fresh air in a closed room; they have a comprehensive and critical view of the institutional culture. If we dare to listen, we will promote potent agents of change. Practical tip: Curricular designers need to create safe spaces for medical students reflect on negative experiences. Ideally, the reflections should be guided by supervisors acknowledged by students as positive and accessible role models.

Marco Antonio de Carvalho-Filho, MD, PhD is Associate Professor of Emergency Medicine - School of Medical Sciences - State University of Campinas - Brazil and Research Fellow in Medical Education - Center for Education Development and Research in Health Professions (CEDAR) - University Medical Center Groningen - The Netherlands

References

1. Lawrence C, Mhlaba T, Stewart KA, Moletsane R, Gaede B, Moshabela M. The Hidden Curricula of Medical Education: A Scoping Review. Acad Med 2017.
2. Hafferty FW, Martimianakis MA. A Rose By Other Names: Some General Musings on Lawrence and Colleagues' Hidden Curriculum Scoping Review. Acad Med 2017.
3. Schweller M, Costa FO, Antônio M, Amaral EM, de Carvalho-Filho MA. The impact of simulated medical consultations on the empathy levels of students at one medical school. Acad Med 2014;89(4):632-7.
4. Schweller M, Passeri S, Carvalho-Filho M. Simulated medical consultations with standardized patients: In-depth debriefing based on dealing with emotions. Revista Brasileira de Educação Médica 2018;42(1):84-93.
5. Carvalho-Filho MA, Schaafsma ES, Tio RA. Debriefing as an opportunity to develop emotional competence in health profession students: faculty, be prepared! Scientia Medica 2018;28(1):1-9.
6. Schweller M, Ribeiro DL, Celeri EV, de Carvalho-Filho MA. Nurturing virtues of the medical profession: does it enhance medical students' empathy? Int J Med Educ 2017;8:262-267.
7. Monrouxe LV. Identity, identification and medical education: why should we care? Med Educ 2010;44(1):40-9.
8. Boal A. The Aesthetics of the Oppressed. USA and Canada: Routledge (Taylor & Francis Group); 2006.

Article of Interest - Diversity and Inclusion in Medical Schools: The Reality

More students are coming from marginalized groups, but when they arrive they're often told to hide what makes them different.
https://blogs.scientificamerican.com/voices/diversity-and-inclusion-in-medical-schools-the-reality/

Humor, Students and Professionalism

by John Minser, MFA

The use of gallows humors – also called black humor or cynical humor – is widespread in healthcare and is often described by those who use it as a coping mechanism for dealing with the daily stresses of work in the medical field (1). It is also, according to American Medical Association, American Nurses Association and National Association of Social Workers codes of behavior, of dubious professionalism due to the lack of respect for patients that gallows humor can communicate (2-4). Although those who use gallows humor typically report that they use it to cope with the stresses and tragedies of a profession

in healthcare, evidence demonstrating that gallows humor is better than other measures of emotion processing or coping is mixed (5).

Katie Watson, in a broad ethical analysis of dark humor, argues that gallows humor and derogatory humor should not be grouped together based on the distinction between making light of a serious *subject* (i.e. laughing at a particularly ironic patient death) and making light of a *patient (*6). This distinction is important. All of the professionalism codes above indicate that a medical professional must communicate respect, which requires an intersubjective space between patient and provider. If a family does not appreciate the distinction between the ironic nature of the death and actively mocking their deceased loved one, professionalism is still breached. Similarly, a professional should not make cruel jokes at the expense of patients even to a friendly audience.

Therefore, what's required to maintain professional ethics in joking is both a sympathetic room and an awareness of the relative power between the jokester and the occasion of humor (6). 'Punching up' at the expense of fate and mortality is laudable and perhaps beneficial, 'punching down' against patients is unprofessional. Gallows humor is a 'backstage' behavior in Goffman's sense – whether it is tolerated as 'professional' among in-group peers varies based on its context (7). Among a group of doctors, nurses and medical professionals, gallows humor is expected and accepted. It should not, however, be engaged in when patients, family members or members of the public are around to hear it. This, indeed, is the position supported by Watson's analysis.

Students, however, are neither peer nor public, and the behavior that they are exposed to in their early clinical rotations serves as formative material for their acculturation into the medical profession – that is, apart from official codes of conduct, their first experiences "backstage" tell them how members of the profession "really" behave. Their discomfort navigating the social rules surrounding both gallows and derogatory humor – and whether students differentiate between the two – can give us an insight into how students are inducted into the medical profession. Wear, Aultman, Varley, and Zarconi's study of medical student response to derogatory humor found students initially struggling to navigate backstage medical spaces, often being included in instances of questionable humor which they were expected to participate in or at least tolerate (8). Students were not, however, expected to make jokes on their own. One comment in particular stands out in light of Mak-Van der Vossen, Teherani, Van Mook, Croiset, and Kusurkar's *Expectancy-Value-Cost* framework of evaluation: medical students in Wear, et. al's study reported being acutely aware of the rules of the "humor game," with one student claiming, "There's nothing a medical student can gain by [making derogatory jokes]" (8, 9). There's no perceived value in making jokes, but neither is there an expectancy of successful resolution should a student report.

Medical students also reported identifying certain classes of patient as acceptable targets for disrespectful humor – those who were perceived to have caused their own complaints were chief among these acceptable targets, but other identified groups included psychiatric patients, clinic patients, and even sexually attractive patients (8). The existence of "acceptable targets" raises an interesting possibility for medical student reporting of professionalism lapses: they may not report disrespectful communications, because they do not perceive these incidents as lapses. Instead, the hidden curriculum of hospital medical education may be communicating that disrespect toward patients is not itself a lapse, but merely a possible occasion for professionalism lapses – that the lapse exists not in the disrespect but in the location, the tone or the target, exactly the same conditions to be considered with more innocuous jokes. While Watson's distinction between gallows and derogatory humor is important, students engaged in active discourse are being led toward not acknowledging the difference except in examples of egregious comments that "crossed the line."

It's never stated that a repertoire of dark jokes is expected of a well-rounded and competent professional, but nearly all healthcare workers are exposed to and included in instances of both gallows and derogatory humor. The failure to distinguish between gallows and derogatory humor in hospital discourse results an activity which is explicitly discouraged in public codes of professionalism but is being communicated to students as a core part of the coping strategies required to succeed in the profession. Students begin acculturation into the 'backstage' space by occupying a position where there is nothing to be gained by any action but complicity in both relatively-innocuous incongruity-based humor and more pernicious derogatory humor.

In a follow-up study published in 2008, Wear, Aultman, Varley, and Zarconi reached out to panels of residents and attending physicians (10). The panels confirmed many of the findings of their 2006 study, but one physician provided what might be seen as a direction by which the ideals and group cohesion of the medical profession might both be respected: using instances of gallows humor or derogatory humor to evoke reflection. This need not take the form of confrontation or reporting. The physician reported

using reframing devices to refocus care team attention on the human dimension, asking questions such as, “How many of you have an addicted person in your family?” (10)

This approach resists the conflation of gallows and derogatory humor during students’ acculturation to the clinical setting. However, it requires attentive preceptors at both the attending and resident level: students first learning how to “be” in their role as a medical professional can best learn to distinguish between appropriate and inappropriate “backstage” humor with a model of an established professional willing to self-interrogate at moments of potential transgression.

John Minser, MFA, is an Instructor in the Department of Medical Education Program in Medical Ethics, Humanities, and Law at Western Michigan University Homer Stryker M.D. School of Medicine

References

1.Rowe, A., and Regehr, C. (2010). *Whatever gets you through today: An examination of cynical humor among emergency service professionals*. Journal of Loss and Trauma. 15. 448-464.
2. American Medical Association. (2007). *Code of medical ethics, opinion 2.3.3: Informing families of a patient’s death*. Retrieved from https://www.ama-assn.org/delivering-care/informing-families-patient-s-death.
3. American Nurses Association. (2015). *Provision 1, Code of ethics for nurses.* Retrieved from https://www.nursingworld.org/coe-view-only.
4. Workers, N. A. (2008). *NASW Code of Ethics (Guide to the Everyday Professional Conduct of Social Workers)*. Washington, DC: NASW.
5. Craun, S. and Bourke, M. (2014). *The use of humor to cope with secondary traumatic stress.* Journal of Child Sexual Abuse, 23:7, 840-852.
6. Watson, K. (2011). *Gallows humor in Medicine.* The Hastings Center Report. 41:5. 37-45.
7. Goffman, E. (1959). *The Presentation of Self in Everyday Life*. New York: Doubleday Anchor Books.
8. Wear, D., Aultman, J., Varley, J., and Zarconi, J. (2006). *Making fun of patients: Medical students’ perceptions and use of derogatory and cynical humor in clinical settings.* Academic Medicine. 81:5. 454-462.
9. Mak-van der Vossen, M., Teherani A., van Mook, W., Croiset, G., and Kusurkar, R. (2018). *Investigating US medical students’ motivation to respond to lapses in professionalism.* Medical Education. 52:7.
10. Wear, D., Aultman, J., Varley, J., and Zarconi, J. (2008). *Derogatory and cynical humour directed toward patients: views of residents and attending doctors*. Medical Education.

How We Do Harm: A Doctor Breaks Rank About Being Sick in America

Book Review by Leann Poston

How We Do Harm: A Doctor Breaks Rank About Being Sick in America by Otis Webb Brawley, M.D. with Paul Goldberg opens with a raw story set in Grady Memorial Hospital Emergency Room in Atlanta, Georgia. Edna, who waits for hours to be seen with a paper bag in her hand, requests that her breast be reattached. Her diagnosis - breast autoamputation due to stage 4 metastatic breast cancer. Why she waited nine years to be seen and why black women have a higher mortality rate from breast cancer are questions Dr. Brawley, chief medical and scientific officer for The American Cancer Society, attempts to answer. Poverty is the number one driver for a poor health outcome and race is second. Dr. Brawley believes there are poor health outcomes on both ends of the socioeconomic spectrum. The poor get little or no quality care with little preventative care due to a lack of health insurance and the wealthy get too much care with interventions that, at best, have not been scientifically proven to be beneficial and, at worst, may be harmful or fatal.

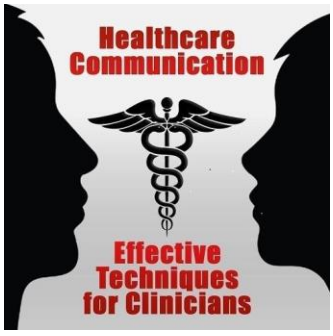
Dr. Brawley tells the story of Helen next, another black woman with breast cancer, but at the other end of the socioeconomic spectrum from Edna. Helen had a good paying job, was married and had insurance. She had a 3cm breast cancer which was also receptor negative. She felt relieved that she had great insurance, support and a steady income. Treatment with high dose chemotherapy was followed by an autologous bone marrow transplant. After suffering significant complications, she was not able to return

to work for a year. The reoccurrence of her metastatic breast cancer was untreatable because she had reached her maximum lifetime dose of chemotherapy and radiation and ironically maximum benefit limit on insurance coverage as well. She ended up in Grady oncology clinic to see Dr. Brawley due to her lack of insurance and subsequently became his colleague in the fight against breast cancer in women of color.

The themes of the book seem to be that being on either end of the financial and treatment spectrum can be detrimental to health and that treatment choices should be based on science not market forces or providing false hope to cancer patients. A comparison between the use of medications and scans to diagnose illness shows that the United States treats more and images more patients than Canada, but their lifespan is approximately three years longer than ours. Interestingly, Dr. Brawley pointed out that if you did need an MRI you were more likely to get it done on a timely basis in Canada than in the United States. To make his point about excess and the U.S. patient's conception of good medical care, Dr. Brawley tells the story of an upper middle class, insured, educated woman with Stage 1A colon cancer, who was diagnosed early and had an excellent surgery with more than 15 nodes biopsied and who sought chemotherapy because she wanted zero chance of a re-occurrence of the cancer. Her first oncologist told her that chemotherapy was not warranted, and the risks outweighed the benefits. A second oncologist concurred. She sought the care of a third oncologist who provided the requested chemotherapy. She informally consulted with Dr. Brawley who told her that the chemotherapy was a poor choice and she should stop it immediately. She chose to disregard this advice. Dr. Brawley concluded that she has increased her risk for leukemia for the next 10 to 15 years and the doctor who provided treatment earned an additional $5,000 for his office.
The tone of the book is impassioned with a purpose of providing a wake-up call to patients seeking treatment. No longer can we claim ignorance about the failings of our current healthcare system. The conflicting goals of humanistic medicine and financial interests are obvious, but solutions are not in sight. Lobbyists and large conglomerates of pharmaceutical companies will ensure that drug prices remain high, direct to consumer advertising will educate patients with skewed data to encourage them to seek unnecessary and perhaps harmful treatment, and productivity requirements will make it difficult for physicians to fully educate their patients on the risks of medical excess. While these points seem valid, Dr. Brawley did not provide a map to changing healthcare for the better and his strong bias towards academic medicine was apparent. Hopefully, educated consumers may take the first step by not pushing doctors to prescribe unwarranted medications and treatments.

Brawley, O. W., & Goldberg, P. (2012). *How we do harm: A doctor breaks ranks about being sick in America*. New York: St. Martins Press. 317 pages

Leann Poston, MD, is Assistant Dean of Admissions and Career Advancement at WSU-Boonshoft School of Medicine in Dayton, Ohio.



Listen to the ACH/DocCom Podcast while you're commuting or exercising

The **Academy of Communication in Healthcare** and **DocCom** teamed up to sponsor a **podcast** – Healthcare Communication: Effective Techniques for Clinicians. Launched in late January, the 25-minute weekly podcast has over 2,600 downloads on topics such as Communicating with Second Victims: Improving the Well-Being of the Health Team by Albert Wu, MD, MPH, a keynoter at the APHC Conference. Check out the list of released podcasts at: **http://bit.ly/ACHDocComPodcast** or on your favorite podcast platform.

Professional Formation Newsletter Associate Editors:

Alya Heirali
Babu Krishnamurthy
David Doukas
Hanke Dekker

Janet de Groot
John Spandorfer
Julie Agris
Leann Poston – book and film reviews
Lorena Novaes
Marco Filho
Nazia Viceer
Patricia Soares
Patrick Herron
Preston Reynolds – biographies
Raul Perez
Rebekah Apple – bios and professionalism news
Sally Fortner
Stephen Gambescia – interdisciplinary issues
Tyler Gibb – ethics, law and professionalism
Virginia Bartlett

Please contact **Janet de Groot** if you'd like to contribute articles to this newsletter.

If you know someone who would benefit from reading Professional Formation, please pass this along.
Sign up at **http://www.professionalformation.org/Contact Us.**